DMV 41SB
7/93

SAFETY BELT WAIVER CERTIFICATE

Physician Certification of Disability

PART I – TO BE COMPLETED BY APPLICANT

TYPE OR PRINT IN BLUE OR BLACK INK

Name		
Mailing Address		
City	State	Zip

For Identification Purposes Only

Driver License/Non Operator ID Number
Social Security Number
Date of Birth

PART II – CERTIFICATION BY LICENSED PHYSICIAN

I hereby certify that the above named person has a physical disability which prevents the use of a safety belt in accordance with West Virginia Code § 17C-15-49(b).

☐ **PERMANENT** ☐ **TEMPORARY – Duration of Waiver Period** _____
From Date of Certification

A. NATURE OF PHYSICAL DISABILITY

B. REASON THAT RESTRAINT BY A SAFETY BELT IS INAPPROPRIATE

C. ALTERNATE RESTRAINT SYSTEM (IF ANY) REQUIRED TO BE USED BY THE NAMED PERSON (OPTIONAL) (AT DISCRETION OF PHYSICIAN)

Signature of Licensed Physician	Date
Physician's License Number	State

Printed Name and Address of Physician

Phone:

TO ALL LAW ENFORCEMENT AGENCIES

This form, when Part I is completed by the applicant, and when Part II is completed in full and signed by the licensed physician, shall serve as waiver of the Motor Vehicle Safety Belt Requirements prescribed by West Virginia Code §17C-15-49. The information contained on this form is subject to verification by any law enforcement officer.

PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING APPLICATION

Applicant

1. Please complete Part I of the application.

2. Take the application to a physician of your choice, licensed in the United States to complete Part II.

Physician

1. Physician: Please complete sections A and B of Part II. Complete Part C only if you recommend the use of an alternative restraint system. Completion of parts A and B are required by WV Code §17C-15-49(b) in order to effectuate the waiver of safety belt use. Completion of Part C is at your discretion.

2. Please indicate whether the condition is permanent or temporary, and indicate period of time waiver is valid, if applicable.

3. Please sign the application and provide your printed name, address and state license number. Please indicate state of licensure as well as your phone number.

4. Return the completed application with your signed certification to the applicant.

APPLICANT

*Keep this completed form in your motor vehicle in a safe place, such as your glove compartment, or carry it with you if you are in another vehicle. You will be required to show this waiver if you are stopped by a law enforcement officer.

*You may make copies of this form. Your physician will have to complete another form if you lose your only copy.